Missouri Department of Health and Senior Services
Time Critical Diagnosis -Trauma Systems Task Force Webinar Highlights
April 21, 2010; 1:30-4:15 PM

Those participating: Dr. Samar Muzaffar, Department of Health and Senior Services (DHSS); Mark Alexander, CoxHealth: Charles Anderson, Callaway County Ambulance District; Sandy Brennecke, SSM Cardinal Glennon Children's Medical Center; Chief Kent Cantrell, Excelsior Springs Fire Department; Karen Connell, DHSS; Dr. Jeff Coughenour, University Hospital and Clinics; Lori Davis, North Kansas City Hospital; Marcia Dial, Scotland County Memorial Hospital; Joan Eberhardt; DHSS; Jason Elliott, Noreen Felich, Children's Mercy Hospital; Cindy Gillam, DHSS; Robert Grayhek, St. Francis Medical Center; Christine Green, SSM Cardinal Glennon Children's Medical Center; Paul Guptill, Missouri Hospital Association; Mike Hicks, Mid-America Regional Council; Dr. Elliott Hix, Scotland County Memorial Hospital; Chris Hoag-Apel, Freeman Medical Systems; Antoinette Kanne, St.John's Mercy Medical Center; Diana Kraus, St. Louis Children's Hospital; Dean Linneman, DHSS; David McKnight, Heartland Regional Medical Center; Bryant McNally, Missouri Hospital Association; Deborah Markenson, DHSS; Ruby Mehrer, LifeFlight Eagle; Julie Nash, Barnes-Jewish Hospital; Greg Natsch, DHSS; Carol Nierling, University Hospital and Clinics; Eric Roberts, Research Medical Center; Michael Ross, Freeman Ambulance Service; David Seastrom, Children's Mercy Hospital; Dr. Douglas Schuerer, Washington University; Ted Shockley, St. John's Regional Hospital; Sandy Woods, St. John's Regional Medical Center; and Beverly Smith, DHSS.

The full recording of the webinar can be found at: Trauma webinar for April 21, 2010 click here or go to: http://stateofmo.na4.acrobat.com/p53953940/

Dr. Muzaffar convened the group and reviewed the 2010 schedule of meetings. (Attachment 1) She also mentioned that the group would finalize documents discussed on this webinar at the in person meetings.

Level IV Trauma Center Regulation Discussion

- Much discussion has been focused during the last several meetings on whether to expand standards for Level IV centers that have the capacity to provide care beyond the triage and transport function for select trauma patients. A vote was taken to capture the sentiment of the group regarding Level IV centers admitting and observing patients rather than only performing traditional triage/transfer functions. It was the general consensus of those on the call that level IV trauma centers should serve triage and transport functions and that there be no additional standards added in these regulations at this time for those facilities that may not quite meet Level III capacity but may exceed Level IV capacity standards . An alternate type of pathway could be considered for level III centers when discussion begins on the older regulations. The final decision regarding these regulations is scheduled to take place at the May 20, 2010 meeting.

  There were also questions about what types of trauma patients the rural and critical access hospitals see and admit. The centers present did not have that information readily accessible and agreed to look at their 2009 data. The point was made that this should not affect business patterns as it appears that most of these patients are currently transferred to larger centers.

  The final decision on these regulations will be made at the May 20, 2010 meeting. In the interim, the Department will collect additional information from critical access hospitals so an informed decision can be made. The type of information that will be compiled in aggregate includes:
  1. What types of trauma patients and injury patterns are critical access hospitals seeing?
  2. Are critical access hospitals admitting trauma patients?
     - If yes, how many patients are admitted and how many patients are transferred?
     - If yes, what types of patients and injury patterns are being admitted?

- Concerns were expressed that if make regulations for Level IV designation too restrictive, may discourage small hospital from applying and may impact scope of services available in the rural areas.

- The flip-side of this concern is assuring that state standards are appropriate for what is in the best-interest of the patient and accurately distinguishing and categorizing facility capacity for care and treatment of trauma patients so those patients are transported to the facilities best equipped to meet their needs.

Trauma Triage/Transport Protocol

- Dr. Muzaffar identified the statutory authority for the Department to promulgate triage and transport protocol for trauma patients—190.185, 190.200 and 190.243 RSMo.

- Dr. Richard C. Hunt, Director of the Division of Injury Response, National Center for Injury Prevention and Control, Atlanta, Georgia one of the authors of *Guidelines for Field Triage of Injured Patients, Recommendations of the National Expert Panel on Field Triage* –has been invited to participate in one of the Trauma Task Force meetings and arrangements are pending. (He is tentatively scheduled to visit the state for the August 19, 2010 Trauma Task Force meeting in Jefferson City.)

- Much discussion was held, primarily regarding the concerns expressed from those in the EMS community, regarding the specificity of the trauma triage and transport protocol. They stated that as guidelines this level of detail was welcomed but as a regulation-based protocol that detail becomes too difficult to keep updated and may put them in a position of being required to perform antiquated practices. The differences between the companion documents and protocols were discussed.

- Options for course of action included the following:

Options	Advantaged Discussed	Disadvantages Discussed
1. Use the CDC National Guideline as Missouri's protocol with Missouri specifics in companion document	• Acceptable floor • Believed easier to follow • Received majority of votes on this call—14 (67%) out of 21 voting	• Additional detail had been added to include Missouri insights and practices into approach • Lose adaptations made so protocol better fits Missouri's center designation levels and needs • Majority of people involved with creating current document not present
2. Simplify Missouri Version	• Separate pediatric from adult protocol and simplify pediatric vital sign section • Streamline formatting • Identifies key issues and adaptations that improve national protocol for Missouri use	• Detail included because of prior request
3. Maintain Missouri version but clean	• Get advantages of work and	• Too detailed

up presentation	discussion invested to improve protocol	• May be confusing • Too difficult to keep updated in regulations

- Comparison of options will be done at the May meeting of the Trauma Task Force with the group recommending preferred option. DHSS will work on compiling versions of the different options that can be better compared.

- As with the level IV regulations, a vote was taken to capture the sentiment of the group regarding the options for the triage/transport protocol and the discussion will continue during the May meeting.
    - As mentioned above, the majority present voted to adopt the CDC protocol and place Missouri specific factors in a companion document.
    - The group also voted to put pediatric specifics into a separate protocol and to simplify the pediatric vital signs to the CDC language. They also discussed having a companion document to the pediatric protocol.
    - Dr. Muzaffar noted that all options are viable.

Community Based Plan

- There was confusion about the community based plan regulations and questions that the proposed language could present a barrier to establishing community plans to address unique issues of the region or community, so time was taken to explain the purpose and statutory authority for these plans, the language in the current draft, and the approval process.

- It was also discussed that this plan is still in draft form and open to discussion and modification.

- The statutory phrase "clinical research and guidelines" was discussed. It was mentioned that an example of what that could be will be built into the plan. It was discussed that emerging national or international standards (eg data supporting 4.5 hours for lytics or updates in COT/CDC triage transport) and guidelines are acceptable and that it does not mean that everyone must produce original research and peer-reviewed papers. It has also been discussed previously that this could include emerging local and regional advancements and data that would warrant a different practice from the state's for that region or the state.

- General concerns and explanations expressed included:
    - The application and approval process had too many steps
        - It was discussed that the steps built in were included as a buffer for the communities and to provide the expertise outside the department that had been requested. MHA had suggested removing review by the SAC subcommittee of regional EMS medical directors. EMS representatives requested that it remain. MHA was okay with it remaining. A request to the group was made for suggestions for specific changes to the structure and flow of the community based plan. No specific suggestions for change to the structure and flow of the plan were made. Minor edits were done.
    - the approval process appears to be subjective,
        - Statute language was discussed (developed by hospitals, physicians, and EMS providers and based in clinical research, guidelines, assessment of capacity and mechanism to evaluate effect on medical outcomes). It was mentioned that the language on page two 4B was attempting to provide specificity. The thirty days on page two 4B1 and 2 was changed to forty-five days. No major suggestions at this time.
    - need clarifications on transport protocol in order to determine if need community/regional plan

        - Further language around “transport to center that requires least amount of transport time” will be developed in stroke and STEMI protocols
        - Continued discussion of trauma protocol; it was mentioned that current transport scheme with Missouri modifications provides more flexibility and inclusion for Missouri hospitals than the CDC language
    - there were varying opinions on what levels of review were appropriate
        - some stated that only review by the regional EMS council and medical director was necessary. The potential buffer that review by the SAC subcommittee of regional EMS medical directors provides for each region was discussed. It was also discussed that no body outside of the Department and the local ambulance medical directors has any authority to give approval and that the SAC, its subcommittees, and the regional EMS councils and medical directors are advisory. The group kept the levels of review at this time.

- Dr. Muzaffar explained that this is still draft and comments are welcome. Specific editing recommendations were made during the webinar and department staff will revise and circulate subsequent draft with the trauma task force prior to the next meeting.